State of California Office of Administrative Law

In re:

California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections:

Amend sections: Repeal sections:

NOTICE OF APPROVAL OF EMERGENCY REGULATORY ACTION

Government Code Sections 11346.1 and 11349.6

OAL File No. 2014-1107-05 EE

The California Health Benefit Exchange (HBEX) submitted this emergency readopt action to maintain the regulations adopted in OAL file no. 2014-0512-01E, which added section 6460 to title 10 of the California Code of Regulations. Section 6460 incorporates by reference the 2015 Standard Benefit Plan Designs, which standardize the way health insurance issuers design their health plans.

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 11/17/2014 and will expire on 5/22/2016. The Certificate of Compliance for this action is due no later than 5/21/2016.

Date: 11/17/2014

> nds**∉**y McNeill Attornèv

For:

DEBRA M. CORNEZ

Director

Original: Peter Lee

Copy: Brandon Ross

STATE OF CALIFORNIA OFFICE OF ADMINIST NOTICE PUBLICATION	I/REGULATIONS SI	DBMISSION	See instru		For use by Secretary of State only
OAL FILE NOTICE FILE NUMBER NUMBERS Z	REGULATORY ACTION NUMBER EMERGENCY NUMBER 2014-1107-05				ENDORSED FILED
	For use by Office of Adm	inistrative Law (OAL) o			IN THE OFFICE OF
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		1	OFFICE OF STRATIVE LASS		Notes - Borren
			NET SATIVE LAW		DESTA BOWEN STORETARY OF STATE
NOTIC			REGULATIONS		
California Health Bene	Fit Exchange				AGENCY FILE NUMBER (If any)
A. PUBLICATION OF NOTI		blication in Notice	Register)		
1. SUBJECT OF NOTICE		TITLE(S)	FIRST SECTION AFFE	CTED	2. REQUESTED PUBLICATION DATE
3. NOTICE TYPE Notice re Proposed Regulatory Action Oth	1	DNTACT PERSON	TELEPHONE NUMBER		FAX NUMBER (Optional)
OAL USE ACTION ON PROPOSE ONLY Approved as Submitted	D NOTICE Approved as Modified	Disapproved/ Withdrawn	NOTICE REGISTER NU	JMBER	PUBLICATION DATE
B. SUBMISSION OF REGUI			and the sale of th		
fa. SUBJECT OF REGULATION(S)	, , , , , , , , , , , , , , , , , , ,	men submitting re		NIC DEL ATER O	
2015 Standard Benefit Desig	ın	•	2014-0512-0		AL REGULATORY ACTION NUMBER(S)
2. SPECIFY CALIFORNIA CODE OF REGULATION	S TITLE(S) AND SECTION(S) (Including	title 26, if toxics related)	1	01L	
SECTION(S) AFFECTED	6460			,	
(List all section number(s) individually. Attach	AMEND				
additional sheet if needed.)					
TITLE(S)	REPEAL				
TYPE OF FILING					
Regular Rulemaking (Gov.	Псиго				
Code §11346) Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3,	Certificate of Compliance: below certifies that this ag provisions of Gov. Code §§ before the emergency reg	ency complied with the 11346.2-11347.3 either ulation was adopted or	Emergency Readopt Code, §11346.1(h))	t (Gov.	Changes Without Regulatory Effect (Cal. Code Regs., title 1, \$100)
11349.4) Emergency (Gov. Code, §11346.1(b))	within the time period req	d or withdrawn	Other (Specify)		Print Only
ALL BEGINNING AND ENDING DATES OF AVA	emergency filing (Gov. Cod		THE RULEMAKING FILE (Ca). Code F	Reas title 1 644 as	d Cov Code 511747 1)
EFFECTIVE DATE OF CHANGES (Gov. Code, §§			The Late of the Local Code (negs. ade 1, 944 al	u dov. Code 911347.1)
October 1 (Gov. Code §11343.4(a))	Effective on filing w Secretary of State	ith §100 Changes V	ct . other (Specific)	
CHECK IF THESE REGULATIONS REQUESTIONS OF THE STORES OF TH	399) (SAM §6660)		R CONCURRENCE BY, ANOTH ractices Commission	HER AGENCY OF	State Fire Marshal
Other (Specify)					State the Marshall
contact person randon Ross		TELEPHONE NUMBER 916-228-8281	FAX NUMBER (O		E-MAIL ADDRESS (Optional)
. I certify that the attache	d (4)				prandon.ross@covered.ca.gov
I certify that the attache of the regulation(s) iden is true and correct, and	tified on this form, that	the information so	ecified on this form		Office of Administrative Law (OAL) only
or a designee of the hea	d of the agency, and am	authorized to make	this certification.	o company	ENDORSED APPROVED
GNATURE OF AGENCY HEAD OR DESIGNATORY YPED NAME AND TITLE OF SIGNATORY	SNEE / hr	DATE	114		NOV 172014
Peter V. Lee, Ex	ecutive Directo		,	C	Office of Administrative Law
					The Set of

Adopt Section 6460, which is all new regulation text to be added, to read:

SECTION 6460: 2015 STANDARD BENEFIT PLAN DESIGNS

(a) For plan year and calendar year 2015, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2015 Standard Benefit Plan Designs, dated April 17, 2014, which is incorporated by reference.

Authority: Government Code Section 100504

Reference: Government Code Sections 100503 and 100504(c); Health and Safety Code Section 1366.6(e) and Insurance Code Section 10112.3(e)

2015 Standard Benefit Plan Designs

April 17, 2014

2015 Standard Benefit Plan Designs 10.0 EHB



Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		Platinu Coinsurand		Platinum Copay Plan		
Actuarial Valu	e - AV Calculator	88.10	%	88.00	%	
	rail deductible at deductibles for specific services	\$0		\$0		
	Medical	\$0		\$0		
	Brand Drugs	\$0		\$0 \$0		
Individual Out	Denial -uf-pocket maximum	\$0 \$4,00	0	\$4,00	00	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$20		\$20		

dividual Out	Brand Drugs Dental -pf-pocket maximum	\$0 \$0 \$4,000		\$0 \$0 \$4,000	
				Member Cost	Deductib
Common edical Event	Service Type	Member Cost Share	Deductible Applies	Share	Applies
ealth care rovider's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$20		\$20	
ffice or Inic visit	Specialist visit	\$40		\$40	
- 100	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$20		\$20	
ests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$40 10%		\$40 \$150	
rugs to treat	Generic drugs	\$5		\$5	
rugs to treat ness or	Preferred brand drugs	\$15		\$15 \$25	
endition	Non-preferred brand drugs Specialty drugs	\$25 10%		10%	ayay arab da ay ay ay ay ay
utpatient	Facility fee (e.g., ASC)	10%		\$250	
urgery	Physician/surgeon fees	10%			
	Emergency room services (waived if admitted)	\$150 \$150		\$150 \$150	a de la companya dela companya dela companya dela companya de la c
eed	Emergency medical transportation	\$150		Ψ,00	
nmediate Itention	Urgent care	\$40		\$40	
	Facility for (e.g. beenfel spem)	10%		\$250 per day up	
ysta latineo	Facility fee (e.g. hospital room) Physician/surgeon fee	10%		to 5 days	
	Mental/Behavioral health outpatient services	\$20		\$20	
iental health shavioral salth, or	Mental/Behavioral health inpatient services	10%		\$250 per day up to 5 days	
ubstance buse heads	Substance use disorder outpatient services	\$20		\$20	
	Substance use disorder inpatient services	10%		\$250 per day up to 5 days	
100 100	Prenatal care and preconception visits	No cost share		No cost share	
reguancy	Delivery and all inpatient Hospital	10%		\$250 per day up	
	services Professional	10%		to 5 days	
	Home health care Outpatient Rehabilitation services	10% \$20	Commence Commence	\$20 \$20	agaran gan ranasan
felp	Outpatient Habilitation services	\$20		\$20	
ecovering or	Skilled nursing care	10%	The state of the s	\$150 per day up	
ther special lealth needs	Durable medical equipment	10%		to 5 days	
		No cost share		No cost share	
	Hospice service	1		No cost share	
hild eye are	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share No cost share		No cost share	- Security Control
Child Dental Biagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No cost share		No cost share	
Child Dental Sasic Services	Amalgam Fill - 1 Surface	20%		\$25	
	Root Canal- Molar			\$300	
Child Dental	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or	***************************************		\$150	
Vajor	Erupted	50%		\$65	li Ligarana insulation
Services	Extraction- Complete Bony Porcelain with Metal Crown			\$160 \$300	
Child	Medically necessary orthodontics	50%		\$1,000	

Summan	of Rone	fite and	Coverage
- uninitial y	OI DOILE	into allu	Coverage

ocket costs.	Share amounts describe the Enrollee's out of		Gold Coinsurance Plan 78.80%		Gold Copay Plan 78.60%	
	rall deductible al deductibles for specific ser	deductible aductibles for specific services			\$0 \$0 \$0 \$0 \$0 \$6,250	
	Medical Brand Drugs Dental -of-socket maximum		\$0 \$0 \$0 \$0 \$6,250			
Common edical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
oro care Sylder's	Primary care visit or non-special visit to treat an injury or illness	alist practitioner	\$30		\$30	
	Specialist visit Preventive care/ screening/ imn	nunization	\$50 No cost share		\$50 No cost share	
10	Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		\$30 \$50 20%		\$30 \$50 \$250	
ga to treat eas or idition	Generic drugs Preferred brand drugs Non-preferred brand drugs		\$15 \$50 \$70		\$15 \$50 \$70	
patient gary	Specialty drugs Facility fee (e.g., ASC) Physician/surgeon fees		20% 20% 20%		20% \$600	
	Emergency room services (walv Emergency medical transportati		\$250 \$250		\$250 \$250	
	Urgent care		\$60		\$60	
	Facility fee (e.g. hospital room) Physician/surgeon fee		20% 20%		\$600 per day up to 5 days	
	Mental/Behavioral health outpat	ient services	\$30		\$30	
th, or	Mental/Behavioral health inpatie	ent services	20%		\$600 per day up to 5 days	
stanos so needs	Substance use disorder outpatie	ent services	\$30		\$30	
	Substance use disorder inpatien	nt services	20%		\$600 per day up to 5 days	
TERRITOR	Prenatal care and preconception Delivery and all inpatient	n visits lospital	No cost share		No cost share \$600 per day up	
	services P Home health care	Professional	20% 20%		to 5 days \$30	
) Waring or	Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care	35	\$30 \$30 20%		\$30 \$30 \$300 per day up	
ith needs	Durable medical equipment		20%	and the second second	to 5 days 20%	
d eye	Hospice service Eye exam 1 pair of glasses per year (or con	ttact langes in lie	No cost share No cost share	ann sinn nalacinnin	No cost share	
9	of glasses) Oral Exam Preventive - Cleaning	MANUTER SPECIAL TOWN	No cost share		No cost share	
gnostic (ventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		No cost share		No cost share	
d Dantel c ICss	Amaigam Fill - 1 Surface		20%		\$25	
d Dantel E	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expose Erupted Extraction- Complete Bony	d Root or	50%		\$300 \$150 \$65 \$160	
	Porcelain with Metal Crown			New York Control of the Control of t	\$300	

	f Benefits and Coverage that a mounts describe the l	· · · · · · · · · · · · · · · · · · ·	Individu Silver Coinsurance	r e Plan	Individu Silver Copay Pl	an
ctuarial Valu	e - AV Calculator		70.309	/6	69.90%	
idividual Ove ther Individu	rall deductible al deductibles for specific	services	N/A		N/A	
	Medical		\$2,000		\$2,000 \$250	
	Brand Drugs Dental		\$250 \$0		\$0	
rdividual Cul	-of-pocket maximum		\$6,250	0	\$6,250	
Common ledical Event	Service I	ype	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
lesith care royider's	Primary care visit or non-sp visit to treat an injury or illn		\$ 45	200	\$45	
ffice or linic visit	Specialist visit		\$65		\$65	
mine vian	Preventive care/ screening	/ immunization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
osta	X-rays and Diagnostic Imag		\$65 20%		\$65 \$250	
	Imaging (CT/PET scans, M Generic drugs	ris)	\$15	X	\$15	
rugs to treat liness or	Preferred brand drugs		\$50	X X	\$50 \$70	X X
ondition	Non-preferred brand drugs Specialty drugs		\$70 20%	X	20%	X
Outpatient	Facility fee (e.g., ASC)		20%		20%	
urgery	Physician/surgeon fees Emergency room services	(waived if admitted)	20% \$250		20% \$250	Х
	Emergency medical transp		\$250	X	\$250	X
leed mmediate ittention	Urgent care		\$90		\$90	
lospital stay	Facility fee (e.g. hospital ro Physician/surgeon fee	om)	20% 20%	X	20%	x
	Mental/Behavioral health o	utpatient services	\$ 45		\$ 45	
lentel health ehavioral lealth, or	Mental/Behavioral health in	patient services	20%	x	20%	X
ubstance buse needs	Substance use disorder ou	tpatient services	\$45		\$4 5	
	Substance use disorder in	patient services	20%	X	20%	Х
	Prenatal care and preconc	eption visits	No cost share		No cost share	
regnancy	Delivery and all inpatient	Hospital	20%	X	20%	X
	services Home health care	Professional	20%		\$45	
	Outpatient Rehabilitation s	ervices	\$45		\$45	
telp ecovering or	Outpatient Habilitation sen	vices	\$45		\$45	
other special	Skilled nursing care		20%	X	20%	X
ioalth needs		t	20%		20%	
	Hospice service		No cost share		No cost share	
Shild eye are	Eye exam 1 pair of glasses per year (of glasses)	or contact lenses in lieu	No cost share No cost share		No cost share No cost share	
Child Dental Plagnostic and Proventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Applicatio Space Maintainers - Fixed	ń	No cost share		No cost share	
Child Dentei Basic Services	Amalgam Fill - 1 Surface		20%		\$25	
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth E Erupted Extraction- Complete Bony		50%		\$300 \$150 \$65 \$160	
	Porcelain with Metal Crow				\$300	
CONTRACTOR SERVICES						

et cost arial V	s. alue - AV Calculator	STREET, CANADA PROCESSOR STREET, CO.	rance Plan 1.50%	Copa 71.0	/ Plan)0%
	Overall deductible Adductibles for specific services		N/A	N	'A
1138	Medical		1,500	\$1,	
idual I	Grand Brugs Dental Out-of-pocket maximum		\$500 \$0 3,250	\$5 \$ \$6,:	Ö
mmoi		Member Cost		Member Cost	
cal Ev		Share	Deductible Applies		Deductible A
h care ider's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$45		\$45	
i dali	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests X-rays and Diagnostic Imaging	\$45 \$65		\$45 \$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
e to tr a or	Generic drugs Preferred brand drugs	\$15 \$50	X	\$15 \$50	X
High	Non-preferred brand drugs Specialty drugs	\$70	X	\$70	Х
allent.	Facility fee (e.g., ASC)	20% 20%	<u> </u>	20% 20%	X
ну	Physician/surgeon fees Emergency room services (waived if admitted)	20% \$250	X	20%	
	Emergency medical transportation	\$250 \$250	X	\$250 \$250	X X
diate lion	Urgent care	\$90	161	\$90	
ital st	Facility fee (e.g. hospital room) Physician/surgeon fee	20% 20%	X	20%	X
	Mental/Behavioral health outpatient services	\$45		\$45	
i haa Aoral Lor	Mental/Behavloral health inpatient services	20%	X	20%	×
ence I neet	Substance use disorder outpatient services	\$45		\$45	
	Substance use disorder inpatient services	20%	X	20%	х
ancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient Hospital services Professional	20% 20%	X	20%	Х
	Home health care	20%		\$45	
	Outpatient Rehabilitation services Outpatient Habilitation services	\$45 \$45		\$45 \$45	
ering	Skilled nursing care	20%	X	20%	x
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
oyo	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share No cost share		No cost share No cost share	
Dama ostic	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No cost share		No cost share	
Dente es		20%		\$25	
Dente	Root Canal-Molar Gingivectomy per Quad Extraction-Single Tooth Exposed Root or Erupted	50%		\$300 \$150 \$65	
as.	Extraction- Complete Bony Porcelain with Metal Crown			\$160 \$300	
	Medically necessary orthodontics	50%		\$1,000	

2015 Standard Benefit Plan Designs 10.0 EHB

ocket costs.	Share amounts describe the Enrollee's out of	Silve HSA P 71.60	lan
dividual Ov	re · AV Calculator arall deductible	\$1,500 integrated	
ther individ	ual geductibles for specific services Medical	N/A	
	Brand Drugs Dental	N/A N/A	
idividual Ou	l-of-postet maximum	\$6,25	00
Common ledical Even	it Service Type	Member Cost Share	Deductible Applies
ealth care rovider's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	20%	X
ffice or linic visit	Specialist visit Preventive care/ screening/ immunization	20% No cost share	X
ests	Laboratory Tests X-rays and Diagnostic Imaging	20% 20%	X X
	Imaging (CT/PET scans, MRIs)	20%	X
rugs to trea	Generic drugs Preferred brand drugs	20% 20%	X
iness or ondition	Non-preferred brand drugs Specialty drugs	20% 20%	X X
iutpatient	Facility fee (e.g., ASC)	20%	X
urgery	Physician/surgeon fees Emergency room services (waived if admitted)	20% 20%	X X
leed nmediate	Emergency medical transportation	20%	×
ttention	Urgent care	20%	X
lospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20% 20%	X
lental healt	Mental/Behavioral health outpatient services	20%	X
ehavioral ealth, or	Mental/Behavioral health inpatient services	20%	x
ubstance buse needs	Substance use disorder outpatient services	20%	X
	Substance use disorder inpatient services	20%	x
	Prenatal care and preconception visits	No cost share	
regnancy	Delivery and all inpatient Hospital services Professional	20% 20%	X
	Home health care	20%	X
ielp	Outpatient Rehabilitation services Outpatient Habilitation services	20% 20%	X X
ecovering o ther special		20%	X
ealth needs		20%	x
	Hospice service	No cost share	X
hild eye are	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share No cost share	
hild Dental Hagnostic Ind	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	No cost share	
reventive Hild Dental	Topical Fluoride Application Space Maintainers - Fixed		
lasic iervicus	Amalgam Fill - 1 Surface Root Canal- Molar	20%	
Shild Dental Aajor	Gingivectomy per Quad	50%	
Services	Extraction- Complete Bony Porcelain with Metal Crown		
Child	Medically necessary orthodontics	50%	Lancación de la constante

2015 Standard Benefit Plan Designs 10.0 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

mber Cost Share amounts describe the Enrollee's out of cket costs.		Silver Coinsurance Plan 100%-150% FPL		Silver Coinsurance Pla 150%-200% FPL		
	ue - AV Calculator	94.80%		88.00%		
	erali deductible ual deductibles for specific services	\$0		N/A	NAMES AND ASSOCIATION OF THE PARTY OF THE PA	
	Medical Brand Drugs	\$0 \$0		\$500 \$50		
lividual Du	Dental t-of-packet meximum	\$0 \$2,250		\$0 \$2,25		
Common dical Even	Service Type	Member Cost g	Deductible Applies	Member Cost Share	Deductil Applies	
alth care	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$3		\$15		
wider's ice or	Specialist visit	\$5				
uc visi)	Preventive care/ screening/ immunization	No cost share		\$20 No cost share		
its.	Laboratory Tests X-rays and Diagnostic Imaging	\$3 \$5		\$15		
	Imaging (CT/PET scans, MRIs)	10%		\$20 15%	x	
ige to treat	Generic drugs Preferred brand drugs	\$3 \$5		\$5 \$15	X	
idition	Non-preferred brand drugs Specialty drugs	\$10 10%		\$25 15%	X X	
petient gery	Facility fee (e.g., ASC) Physician/surgeon fees	10% 10%		15%		
	Emergency room services (waived if admitted)	\$25		15% \$75	Х	
ad nediate	Emergency medical transportation	\$25		\$75	X	
intion	Urgent care	\$6		\$30		
opital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	10% 10%		15% 15%	X	
	Mental/Behavioral health outpatient services	\$3		\$15		
ital Bealth, eviorel lib. or	Mental/Behavioral health inpatient services	10%		15%	х	
stance se needs						
	Substance use disorder outpatient services	\$3		\$15		
	Substance use disorder inpatient services	10%	iyaal ada	15%	X	
prancy	Prenatal care and preconception visits	No cost share		No cost share		
	Delivery and all inpatient Hospital services Professional	10% 10%		15% 15%	X	
	Home health care Outpatient Rehabilitation services	10%		15%		
	Outpatient Renabilitation services Outpatient Habilitation services	\$3 \$3		\$15 \$15		
overing or or special	Skilled nursing care	10%		15%	X	
lth needs	Durable medical equipment	10%		15%		
	Hospice service Eye exam	No cost share		No cost share		
d eye	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share No cost share		
d Dentel mostic ventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No cost share		No cost share		
d Dental ic dces	Amalgam Fill - 1 Surface	20%		20%		
d Dental or rices	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	50%		50%		
d	Porcelain with Metal Crown Medically necessary orthodontics	50%				

2015 Standard Benefit Plan Designs 10.0 EHB

Summary	οf	Benefits	and	Coverage
Summarv	OI	Denemis	anu	Coverage

pocket costs. Actuarial Valu	hare amounts describe the Enrolled	e's out of	Silver Coinsut 200%-250 rounded up t	% FPL to 74.0%
Other Individu	rall deductible at deductibles for specific servic Medical Brand Drugs Dental -of-pocket maximum	es	\$1,60 \$250 \$0 \$5,20	iO)
Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care	Primary care visit or non-specialist visit to treat an injury or illness	t practitioner	\$40	
office or clinic visit	Specialist visit		\$50	
	Preventive care/ screening/ immur	nization	No cost share	
	Laboratory Tests		\$40	
ests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		\$50 20%	X
Orage to treat	Generic drugs		\$15	
liness or	Preferred brand drugs		\$35 \$60	X
ondition	Non-preferred brand drugs Specialty drugs	entgreekinen treskrimten erro	20%	X
Dutpatient	Facility fee (e.g., ASC)		20%	
urgery	Physician/surgeon fees Emergency room services (walved	l if admitted)	20% \$250	×
leed mmediate ittention	Emergency medical transportation Urgent care		\$250 \$80	X
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	and a second a second and a second a second and a second	20% 20%	X
	Mental/Behavioral health outpatie	nt services	\$40	
dental health sensoloral seath; or	Mental/Behavioral health inpatient	t services	20%	×
substance abuse needs	Substance use disorder outpatien	t services	\$40	
	Substance use disorder inpatient	services	20%	. X
Pregnancy	Prenatal care and preconception	visits spital	No cost share	X
	services Pro	ofessional	20%	
	Home health care Outpatient Rehabilitation services		20% \$40	
telp	Outpatient Renabilitation services Outpatient Habilitation services		\$40	
ecovering or	Skilled nursing care		20%	X
other special	Durable medical equipment		20%	
	Hospice service		No cost share	
Shild eye	Eye exam 1 pair of glasses per year (or contains)	ad langua in liqu	No cost share	
care	of glasses) Oral Exam	act tenses III lieu	No cost share	
Child Dental Disgnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		No cost share	
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	
Servicus Child Dental Major	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Erupted	I Root or	50%	
Services	Extraction- Complete Bony Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		50%	

Summan	, af	Danaste	and	Coverage

ocket costs.	Share amounts describe the I		Silver Copay Pla 100%-150% FPl 94.90%		6 FPL
dividual Ov	erall saductible		\$0	N/A	
dividual Qu	ual deductibles for specific Medical Brand Drups Dental I-of-pocket maximum	Struces	\$0 \$0 \$0 \$2,250	\$500 \$50 \$0 \$2,250	
Common edical Even	t Service T	уре		uctible Member Cost plies Share	Deductil: Applies
isith care ovider's	Primary care visit or non-sp visit to treat an injury or illne		\$3	\$ 15	
fice or inic visit	Specialist visit		\$5	\$20	
	Preventive care/ screening/ Laboratory Tests		No cost share	No cost share	
818 	X-rays and Diagnostic Imag Imaging (CT/PET scans, MR Generic drugs		\$5 \$50 \$3	\$20 \$100 \$5	
ogs to treat tess or notition	Preferred brand drugs Non-preferred brand drugs Specialty drugs		\$5 \$10	\$15 \$25	X
itpatient rgary	Facility fee (e.g., ASC) Physician/surgeon fees		10% 10% 10%	15% 15% 15%	X
ied	Emergency room services (v Emergency medical transpo		\$25 \$25	\$75 \$75	X X
mediate ention	Urgent care		\$6	\$30	
spilai stay	Facility fee (e.g. hospital roo Physician/surgeon fee	m)	10%	15%	X
	Mental/Behavioral health ou	tpatient services	\$3	\$15	
intel health havioral aith or	Mental/Behavioral health inp	patient services	10%	15%	Х
batance use naeds	Substance use disorder outp	patient services	\$3	\$15	
	Substance use disorder inpa	atient services	10%	15%	X
egnancy	Prenatal care and preconcer Delivery and all inpatient	otion visits [Hospital	No cost share	No cost share	
	services Home health care	Professional	10% \$3	15% \$15	×
lp overing or	Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care		\$3 \$3 10%	\$15 \$15 15%	x
ier special alth needs	Durable medical equipment		10%	15%	^
lid eye	Hospice service Eye exam 1 pair of glasses per year (or	contact lenses in lieu	No cost share No cost share	No cost share	
a Ild Dental Ignostic I Iventive	of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No cost share	No cost share No cost share	
lid Dental sic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		\$25	\$25	
rvices lid Dantal	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exp	and Past -	\$300 \$150	\$300 \$150	
jor rvices	Erupted Extraction- Complete Bony Porcelain with Metal Crown	NOOL OF	\$65 \$160 \$300	\$65 \$160	
lid	Medically necessary orthodo		\$300 \$1,000	\$300 \$1,000	

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fember Cost S ocket costs.	Share amounts describe the Enrollee's out of	Silver Copa 200%-250%	
ctuatiat Valu	e - AV Calculator	73.50%	6
	erall deductible usi deductibles for specific services	N/A	
Alles Morstot	Medical	\$1,600	
	Brand Drugs Dental	\$250 \$0	
ndividual Cu	61-pocket maximum	\$5,200)
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
lealth care trovider's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$40	
iffice or	Specialist visit	\$50	
linic visit	Preventive care/ screening/ immunization	No cost share	
	Laboratory Tests	\$40	
ests .	X-rays and Diagnostic Imaging	\$50 \$250	
	Imaging (CT/PET scans, MRIs) Generic drugs	\$250 \$15	
Trugs to freat liness or	Preferred brand drugs	\$35 \$60	X
ondition	Non-preferred brand drugs Specialty drugs	20%	X
Suspatient	Facility fee (e.g., ASC) Physician/surgeon fees	20% 20%	
orgery	Emergency room services (waived if admitted)		×
leed mmodiate	Emergency medical transportation	\$250	X
ittention	Urgent care	\$80	
kospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20%	X
	Mental/Behavioral health outpatient services	\$40	
Kental health sehavioral sealth, or	Mental/Behavioral health inpatient services	20%	X
substance sbuse needs	Substance use disorder outpatient services	\$40	
	Substance use disorder inpatient services	20%	x
	Prenatal care and preconception visits	No cost share	
Pregnancy	Delivery and all inpatient Hospital	20%	x
	services Professional Home health care	\$40	
	Outpatient Rehabilitation services	\$40	
Help recovering o	Outpatient Habilitation services	\$40	
other special	Skilled nursing care	20%	X
health needs		20%	
	Hospice service	No cost share	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in li of glasses) One Exam	No cost share No cost share	
Child Dental	Oral Exam Preventive - Cleaning		
Diagnostic and	Preventive - X-ray Sealants per Tooth	No cost share	
Preventive	Topical Fluoride Application Space Maintainers - Fixed		
Child Dental Basic Services	Amalgam Fill - 1 Surface	\$25	1227
	Root Canal- Molar Gingivectomy per Quad	\$300 \$150	
Child Dantal Malas	Extraction- Single Tooth Exposed Root or	\$100 \$65	
Major Services	Erupted Extraction- Complete Bony Porcelain with Metal Crown	\$160 \$300	

Summary	of B	enefits	and	Coverage

cket costs	st Share amounts describe the Enrollee's out of s. Blue - AV Calculator		re Plan 60%	Bron HSA P 59.40	lan
	Overall daductible	\$5,000 integrat	ed Med/Rx Ded	\$4,500 integra	ted Med/R
ter inatv	idual deductibles for apacific services Medicel Brand Orugs Dental Dyf-br-pocket maximum	N \$	//A //A 50 250	N/A N/A N/A \$6,20	.
Common dical Evi		Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
alth care ovider's ich or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$60	After 1st three non-preventive visits	40%	x
nic vian	Specialist visit Preventive care/ screening/ immunization	\$70 No cost share	Х	40% No cost share	X
	Laboratory Tests	30%	X	40%	X
sta	X-rays and Diagnostic Imaging	30%	X	40%	Х
	Imaging (CT/PET scans, MRIs) Generic drugs	30% \$15	X	40% 40%	<u>X</u>
ugs to tre leas or	Preferred brand drugs	\$50	X	40%	X
nelition	Non-preferred brand drugs	\$75	Х	40%	X
toatient	Specialty drugs Facility fee (e.g., ASC)	30%	X	40%	X
gery	Physician/surgeon fees	30%	X	40% 40%	X
	Emergency room services (waived if admitted)	\$300	×	40%	X
ed nedlate ention	Emergency medical transportation Urgent care	\$300 \$120	X After 1st three non- preventive	40% 40%	X
			visits		
spital ata	Facility fee (e.g. hospital room)	30%	X	40%	X
	Physician/surgeon fee	30%	<u> </u>	40%	X
stel heal	Mental/Behavioral health outpatient services	\$60	After 1st three non- preventive visits	40%	×
iaviorai	Mental/Behavioral health inpatient services	30%	X	40%	X
ith, or stance so need	Substance use disorder outpatient services	\$60	After 1st three non- preventive visits	40%	×
	Substance use disorder inpatient services	30%	X	40%	x
	Prenatal care and preconception visits	No cost share		No cost share	
gnancy	Delivery and all inpatient Hospital	30%	V		
	services Professional	30%	X	40% 40%	X
	Home health care	30%	×	40%	X
	Outpatient Rehabilitation services	\$60	X	40%	X
p overing c	Outpatient Habilitation services	\$60	X	40%	X
er specie	Skilled hursing care	30%	X	40%	X
ith need	Durable medical equipment	30%	X	40%	X
	Hospice service	No cost share	X	No cost share	Х
id eye I	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share No cost share		No cost share No cost share	
id Dental gnostic ventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No cost share		No cost share	
id Dental ic vices		20%		20%	
id Den(al or Aces	Root Canal-Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	50%		50%	
	Porcelain with Metal Crown				
ld					

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Summary of Benefits and Coverage	
Member Cost Share amounts describe the Enrollee's out of	Catastrophic Plan

ocket costs. Actuarial Valu	s - AV Calculator		
ndividual Ove	rali deductible	\$6,600 integrated	Med/Rx Dec
)ther Individu	al deductibles for specific services Medical	N/A	
	Brand Drugs Dental	N/A N/A	
ndividual Out	-of-pocket maximum	\$6,60	0
Common		Member Cost	Deductible
Medical Event	Service Type	Share	Applies
legith care	Primary care visit or non-specialist practitioner visit to treat an injury or illness	0%	After 1st three non- preventive visits
office or sinic visit	Specialist visit	0%	X
diring vien	Preventive care/ screening/ immunization	No cost share	
	Laboratory Tests	0%	X
iests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs) Generic drugs	0% 0%	X
Drugs to treat	Preferred brand drugs	0%	X
liness or sondition	Non-preferred brand drugs	0%	X
Outoatlant	Specialty drugs Facility fee (e.g., ASC)	0% 0%	X
surgery	Physician/surgeon fees	0%	X
	Emergency room services (waived if admitted)	0%	X
Need	Emergency medical transportation	0%	X
mmediate attention	Urgent care	0%	After 1st three non- preventive visits
	Facility fee (e.g. hospital room)	0%	X
Hospital stay	Physician/surgeon fee	0%	X
	Mental/Behavioral health outpatient services	0%	After 1st three non- preventive visits
Mantal health ochavrorei	Mental/Behavioral health inpatient services	0%	X
health, or			
substance abuse needs	Substance use disorder outpatient services	0%	After 1st three non- preventive visits
	Substance use disorder inpatient services	0%	X
	Prenatal care and preconception visits	No cost share	
Pregnancy	Delivery and all inpatient Hospital	0%	X
	services Professional	0%	X
	Home health care Outpatient Rehabilitation services	0% 0%	X
Help	Outpatient Habilitation services	0%	X
recovering or	Skilled nursing care	0%	X
other special health needs	Durable medical equipment	0%	X
	Hospice service	No cost share	х
	Eye exam	No cost share	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	x
ou vie	Oral Exam		
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray	Na cook	
and	Sealants per Tooth	No cost share	And the second second
Preventive	Topical Fluoride Application Space Maintainers - Fixed		
Child Dental Basic	Amalgam Fill - 1 Surface	20%	×
Services	Root Canal- Molar		X
Child Dental	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or	man.	X
Major Services	Erupted	50%	X
odi vives	Extraction- Complete Bony Porcelain with Metal Crown		X
	Forcedin with Micial Crown	(^
Child Orthodontics	Medically necessary orthodontics	50%	X

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Notes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for the deductibles in High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the in-network family deductible and out of pocket maximum. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the carrier pays all costs for covered services for all family members.
- 2) For HDHPs linked to HSAs, in a family plan, each individual in the family must meet a deductible of \$2,600 until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in a family plan, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
- 3) Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
- 5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 6) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month.
- 7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
- 8) For drugs to treat an illness or condition the copay or coinsurance applies to the prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.
- 9) For the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental benefit design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to copays for non-preventive child dental benefits.

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Date: April 17, 2014



Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	88.10%	88.00%
Individual Overall deductible	\$0	\$0
Other individual deductibles for specific services Medical	\$0	\$0
Brand Drugs	\$0	and the second s
Dental Individual Out-of-pocket maximum	\$0 \$4,000	\$0 \$4,000
		E POSTO SE LO S

anvidual Out	Medical Brand Drugs Dental of-pocket maximum	\$0 \$0 \$0 \$4,000)	\$0 \$0 \$0 \$4,000			
Common edical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies		
ealth care revider's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$20		\$20			
tice or Inic visit	Specialist visit	\$40		\$40			
	Preventive care/ screening/ immunization	No cost share		No cost share			
	Laboratory Tests	\$20		\$20			
ests .	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$40 10%		\$40 \$150			
ugs to treat	Generic drugs	\$5		\$5			
ness of	Preferred brand drugs Non-preferred brand drugs	\$15 \$25		\$15 \$25			
ndition	Specialty drugs	10%		10%			
utpatient legery	Facility fee (e.g., ASC) Physician/surgeon fees	10% 10%		\$250			
ered.	Emergency room services (walved if admitted) Emergency medical transportation	\$150 \$150		\$150 \$150			
imediale tention	Urgent care	\$40		\$40			
ospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	10% 10%		\$250 per day up to 5 days			
	Mental/Behavioral health outpatient services	\$20		\$20			
ental health shavioral satth, or	Mental/Behavioral health inpatient services	10%		\$250 per day up to 5 days			
ibstance ouse needs	Substance use disorder outpatient services	\$20		\$20			
	Substance use disorder inpatient services	10%		\$250 per day up to 5 days			
	Prenatal care and preconception visits	No cost share		No cost share			
regnancy	Delivery and all inpatient Hospital	10%		\$250 per day up			
	Services Professional Home health care	10% 10%		to 5 days \$20			
	Outpatient Rehabilitation services	\$20		\$20 \$20			
eip scovering or ther special	Outpatient Habilitation services Skilled nursing care	\$20 10%		\$150 per day up to 5 days			
ealth needs	Durable medical equipment	10%		10%	- and the second second		
	Hospice service	No cost share		No cost share			
hild eye are	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share No cost share		No cost share No cost share			
hild Dental lagnostic nd reventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered			
hild Dental asic ervicus	Amalgam Fill - 1 Surface	Not Covered		Not Covered			
hild Decial lajor ervices	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	Not Covered		Not Covered Not Covered Not Covered Not Covered			
hild Inhodontics	Porcelain with Metal Crown Medically necessary orthodontics	Not Covered		Not Covered Not Covered			

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	5	u	n	п	n	ì	3	n	۴	c	и	Ì.	ь	ĸ	ì	n	е	1	п	S	: 1	а	n	d	(c	O	۸	16	2	ra	iÒ	16	•	

ocket costs.	Share amounts describe the Enrollee's out of	Gold Coinsurance 78.809	e Plan	Gold Copay P 78.609	lan
dividual Ov	erall deductible ual deductibles for specific services	\$0		\$0	
dividual Ou	da depositions of specific services Medical Brand Drugs Denial t-of-posist maximum	\$0 \$0 \$0 \$6,250)	\$0 \$0 \$0 \$6,25)
Common		Member Cost	Deductible	Member Cost	Deducti
edical Even	t Service Type	Share	Applies	Share	Applie
selth care ovider's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$30		\$30	
fice or nic visit	Specialist visit	\$50		\$50	
	Preventive care/ screening/ immunization	No cost share		No cost share	
31 5	Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$30 \$50 20%		\$30 \$50 \$250	
uga to trea	Generic drugs Preferred brand drugs	\$15 \$50		\$15 \$50	
ness or adition	Non-preferred brand drugs	\$70		\$70	
Hzatient	Specialty drugs Facility fee (e.g., ASC)	20%		20%	
tgery	Physician/surgeon fees Emergency room services (waived if admitted)	20%		\$600	
ed mediate	Emergency medical transportation	\$250 \$250		\$250 \$250	
ention	Urgent care	\$60		\$60	
epital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20%		\$600 per day up to 5 days	
	Mental/Behavioral health outpatient services	\$30		\$30	
ntal health navioral eith, or	Mental/Behavioral health inpatient services	20%		\$600 per day up to 5 days	
25 Unice USB Reads	Substance use disorder outpatient services	\$30		\$30	
	Substance use disorder inpatient services	20%		\$600 per day up to 5 days	
	Prenatal care and preconception visits	No cost share		No cost share	
gnancy	Delivery and all inpatient Hospital	20%		\$600 per day up	
	services Professional Home health care	20%		to 5 days \$30	
lo .	Outpatient Rehabilitation services Outpatient Habilitation services	\$30		\$30	
overing or	Skilled nursing care	\$30 20%		\$30 \$300 per day up	
ier special Mith needs	Durable medical equipment	20%		to 5 days 20%	
	Hospice service	No cost share		No cost share	
lid eye	Eye exam	No cost share		No cost share	
•	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No cost share		No cost share	
id Denga gnostic L ventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
ld Centel iic vices	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar Gingivectomy per Quad			Not Covered	
ld Dental jor	Extraction- Single Tooth Exposed Root or	Not Covered		Not Covered Not Covered	
rvices	Extraction- Complete Bony Percelsia with Metal Comme	23,0,00		Not Covered	
lid	Porcelain with Metal Crown Medically necessary orthodontics	Not Course		Not Covered	
moderatics		Not Covered		Not Covered	

ember Cost S ocket costs.	Benefits and Coverage thare amounts describe the Enrollee's out of	Individu Silver Coinsurance 70.30%	e Plan	Individu Silver Copay PI 69.90%	an
2012/2012	e-AV Calculator	70.30 // N/A	•	N/A	
	rall deductible al deductibles for specific services			\$2,000	
	Medical Brand Drugs	\$2,000 \$250		\$250	
dividual Col	Dental -of-pocket maximum	\$0 \$6,250)	\$0 \$6,250	
				O management to the book of the total of the	
Common edical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
ealth care roylder's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$4 5		\$45	
fice of Into visit	Specialist visit	\$65		\$65	
uus visu	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$45		\$45	
ests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$65 20%	Х	\$65 \$250	
rugs to treat	Generic drugs	\$15		\$15	
10 229n	Preferred brand drugs Non-preferred brand drugs	\$50 \$70	X	\$50 \$70	X
ondition	Specialty drugs	20%	X	20%	X
utpatient urgery	Facility fee (e.g., ASC) Physician/surgeon fees	20% 20%		20% 20%	
	Emergency room services (waived if admitted)	\$250	X	\$250	X
aed	Emergency medical transportation	\$250	Х	\$250	Х
nmediate Hention	Urgent care	\$90		\$90	
ospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20% 20%	X	20%	Х
	Mental/Behavioral health outpatient services	\$45		\$ 45	
lental health chavioral ealth, or	Mental/Behavioral health inpatient services	20%	X	20%	X.
ubstance Buse needs	Substance use disorder outpatient services	\$45		\$45	
	Substance use disorder inpatient services	20%	X	20%	Χ
	Prenatal care and preconception visits	No cost share		No cost share	
regnancy	Delivery and all inpatient Hospital Professional	20% 20%	X	20%	х
	services Professional Home health care	20%		\$45	
	Outpatient Rehabilitation services Outpatient Habilitation services	\$45 \$45		\$45 \$45	
lelp ecovering or	Skilled nursing care	20%	х	20%	х
dher special leath needs	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
and the same	Eye exam	No cost share		No cost share	
Hild eye are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Plagnostic Ind Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
ihild Dental Iasik	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Services	Root Canal- Molar			Not Covered	
Child Dental	Gingivectomy per Quad			Not Covered	
Aajor	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	L
Services	Extraction- Complete Bony Porcelain with Metal Crown			Not Covered Not Covered	
Shild					
unia Ombodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Member Cost ocket costs.	of Benefits and Coverage Share amounts describe the Enrollee's out of	Colnsu	SHOP Silver Irance Plan 1.50%	SII Copa	OP ver y Plan 00%			
idividual Qu	arall deductible ual deductibles for specific services Madical Brand Drugs Dantal		N/A 1,500 \$500 \$0	N/A \$1,500 \$500 \$0				
idividual Ou	t-of-posket mas/mum	S Member Cost	6,250	\$6, Member Cost				
ledical Even	t Service Type	Share	Deductible Applies	Share	Deductible Appl			
ealth care rovider's filse or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$45	The Control of the Co	\$45				
linto visit	Specialist visit Preventive care/ screening/ immunization	\$65 No cost share		\$65 No cost share				
	Laboratory Tests	\$45		\$45				
2720	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$65 20%	X	\$65 \$250				
ruge to trea	Generic drugs	\$15		\$15				
iness or Ondition	Non-preferred brand drugs	\$50 \$70	X	\$50 \$70	X X			
utpatient	Specialty drugs Facility fee (e.g., ASC)	20%	<u> </u>	20%	. X			
urgery	Physician/surgeon fees Emergency room services (waived if admitted)	20% \$250	×	20% \$250				
48 0	Emergency medical transportation	\$250	X	\$250 \$250	X			
nmediate Rention	Urgent care	\$90		\$90				
ospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20% 20%	X	20%	x			
	Mental/Behavioral health outpatient services	\$45		\$45				
ental-fleaith inevioral saith or	Mental/Behavioral health inpatient services	20%	×	20%	x			
betance use heeds	Substance use disorder outpatient services	\$45		\$45				
	Substance use disorder inpatient services	20%	x	20%	x			
	Prenatal care and preconception visits	No cost share		No cost share				
egnancy	Delivery and all inpatient Hospital	20%	X	20%	x			
	Services Professional Home health care	20% 20%		\$45				
elp:	Outpatient Rehabilitation services Outpatient Habilitation services	\$45 \$45		\$45 \$45				
covering or	Skilled nursing care	20%	X	20%	x			
aith needs	Durable medical equipment	20%		20%				
	Hospice service	No cost share		No cost share				
illd eye re	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share No cost share		No cost share No cost share				
ilid Dentel agnicatio d eventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	Not Covered		Not Covered				
niid Dental Bio	Space Maintainers - Fixed Amalgam Fill - 1 Surface	Not Covered		Not Covered				
rvices	Root Canal- Molar			Not Covered				
ilid Dentel	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or	Not Covered		Not Covered Not Covered Not Covered				
rvices	Erupted Extraction- Complete Bony Porcelain with Metal Crown	, tot covered		Not Covered Not Covered				
slid	Medically necessary orthodontics	Not Covered		Not Covered				

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ocket costs.		rollee's out of	Silv HSA F	lan
	lue - AV Calculator		71.60	
	versit deductible dual deductibles for specific s	ervices	\$1,500 integrate	
	Medical Brand Drugs		N/ <i>i</i> N/ <i>i</i>	
	Dental		N// \$6,2	١.
nawausi U	sit-of-posket maximum		Φ0,2	1
Common				
Medical Eve	nt Service Typ	oe .	Member Cost Share	Deductible Applies
Health care	Primary care visit or non-sper visit to treat an injury or illnes		20%	x
office or	Specialist visit		20%	X
dinie vislt	Preventive care/ screening/ is	mmunization	No cost share	
	Laboratory Tests		20%	X
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MR		20% 20%	X
	Generic drugs		20%	X
Drugs to tre Uness or	Preferred brand drugs Non-preferred brand drugs		20% 20%	X X
noifibne	Specialty drugs		20%	X
Dutpatient surgery	Facility fee (e.g., ASC) Physician/surgeon fees		20% 20%	X
4.1	Emergency room services (w		20%	X
Need	Emergency medical transpor	tation	20%	X
immediate attention	Urgent care		20%	- X
	Facility fee (e.g. hospital roor	n)	20%	X
Hospital sta	Physician/surgeon fee		20%	X
	Mental/Behavioral health out	patient services	20%	x
Mental besi behavlaral beutth, ar	Mental/Behavioral health inpo	atient services	20%	X
substance abuse need	Substance use disorder outp	atient services	20%	x
	Substance use disorder inpa	tient services	20%	x
	Prenatal care and preconcer	ition visits	No cost share	
Pregnancy.	Delivery and all inpatient	Hospital	20%	X
	services Home health care	Professional	20%	X X
	Outpatient Rehabilitation ser		20%	X
Help recovering	Outpatient Habilitation service	es	20%	x x
other speci	Skilled Hursing Care		20%	^ X
health need	Description of the second seco		20% No cost share	X
	Hospice service Eye exam		No cost share	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu	No cost share	
	of glasses) Oral Exam	1-00		
Child Denta Diagnostic	Preventive - Cleaning Preventive - X-ray	noncounted.	N-40	
and	Sealants per Tooth		Not Covered	
Preventivo	Topical Fluoride Application Space Maintainers - Fixed	and the second		
Child Denta Basic	Amalgam Fill - 1 Surface		Not Covered	
Services	Root Canal- Molar			
Child Denta	Gingivectomy per Quad Extraction- Single Tooth Exp	posed Root or	e gas a constitue	
Major Services	Erupted		Not Covered	
	Extraction- Complete Bony Porcelain with Metal Crown		a a santa di Santa d Santa di Santa di Sa	11.6
contraction and a second				

Summary of Benefits and Co	verage
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Share amounts describe the Enrollee's out of	Silver Coinsu 100%-150	% FPL	Silver Coinsu 150%-200	% FPL
e - AV Calculator erall deductible	94.80		88.00 N/A	PRINCIPAL STATE OF THE
ual deductibles for specific services Medical	\$0		\$500	Allebrary Anna Child Carabilli
Strend Druge Dental	\$0 \$0		\$50	
-of-cookit maximum	\$2,2	50	\$0 \$2,25	0
Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$3		\$15	
Specialist visit	\$5		\$20	
Preventive care/ screening/ immunization	No cost share		No cost share	
Laboratory Tests X-rays and Diagnostic Imaging	\$3 \$5		\$15 \$20	
Imaging (CT/PET scans, MRIs) Generic drugs	10% \$3		15%	X
Preferred brand drugs	\$5		\$5 \$15	Х
Non-preferred brand drugs Specialty drugs	\$10 10%		\$25 15%	X
Facility fee (e.g., ASC) Physician/surgeon fees	10% 10%		15%	
Emergency room services (walved if admitted)	\$25		15% \$75	×
Emergency medical transportation	\$25		\$7 5	X
Urgent care	\$6	100	\$30	
Facility fee (e.g. hospital room) Physician/surgeon fee	10% 10%		15% 15%	X
Mental/Behavioral health outpatient services	\$3		\$ 15	
Mental/Behavioral health inpatient services	10%		15%	X
Substance use disorder outpatient services	\$3		\$15	
Substance use disorder inpatient services	10%		15%	x
Prenatal care and preconception visits	No cost share		No cost share	
Delivery and all inpatient Hospital services Professional	10% 10%		15%	X
Home health care	10%		15% 15%	
Outpatient Rehabilitation services Outpatient Habilitation services	\$3 \$3		\$15 \$15	
Skilled nursing care	2462401000000000000000000000000000000000		15%	X
Durable medical equipment	10%		15%	
Hospice service	No cost share		No cost share	
Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share No cost share		No cost share No cost share	
Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	Not Covered		Not Covered	
Porcelain with Metal Crown				
Medically necessary orthodontics	Not Covered		Not Covered	

2015 Standard Benefit Plan Designs 9.5 EHB

Summary	of Be	enefits	and	Coverage

ocket costs.	hare amounts describe the I	Lindinee 3 out of	Silver Coinsur 200%-250 rounded up t	% FPL
	e - AV Galculator vall deductible	S	N/A	0 74.0%
	al deductibles for specific	services		
	Medical Brand Drugs		\$1,60 \$250	
ndividuat Out	Dental -of-pocket maximum		\$0 \$5,20	0
Common			Member Cost	Deductible
Medical Event	Service T	ype	Share	Applies
loaith care	Primary care visit or non-sp visit to treat an injury or illn		\$40	
ffice or Into visit	Specialist visit		\$50	
	Preventive care/ screening	/ immunization	No cost share	
	Laboratory Tests		\$40	
ests	X-rays and Diagnostic Imag Imaging (CT/PET scans, M		\$50 20%	X
rugs to treat	Generic drugs	160	\$15	
iness or	Preferred brand drugs Non-preferred brand drugs		\$35 \$60	X
ondition	Specialty drugs		20%	X
Outpatient orgery	Facility fee (e.g., ASC) Physician/surgeon fees		20% 20%	
	Emergency room services		\$250	X
lead	Emergency medical transp	ortation	\$250	X
mmediate ittention	Urgent care		\$80	
lospital stay	Facility fee (e.g. hospital ro Physician/surgeon fee	oom)	20% 20%	X
	Mental/Behavioral health o	utpatient services	\$40	
dental health selfavioral sealth, or	Mental/Behavioral health in	npatient services	20%	x
ubstance Ibuse needs	Substance use disorder ou	itpatient services	\$40	
	Substance use disorder in	patient services	20%	x
	Prenatal care and precond	eption visits	No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20% 20%	X
	services Home health care	Professional	20%	
	Outpatient Rehabilitation s		\$40 \$40	
Help recovering or	Outpatient Habilitation ser Skilled nursing care	vices	20%	x
other special	Durable medical equipmer	18	20%	
engici recuta	Hospice service		No cost share	
	Eye exam		No cost share	
Child eye care	1 pair of glasses per year of glasses)	(or contact lenses in lie		
Onlid Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed			
Child Cental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Chila Dental	Root Canal- Molar Gingivectomy per Quad	voced Post or		
Major Services	Extraction- Single Tooth E Erupted Extraction- Complete Bon Porcelain with Metal Crow	У	Not Covered	
and the second	- Stocian manifesta crow	1.00		

	of Benefits and Coverage	

ocket cos	ost Share amounts describe the Enrollee's out of ts. /alue - AV Calculator	Silver Copay Pla 100%-150% FPL 94.90%)% FPL
dividual	Overell deductible	\$0	88.01 N//	
ther Indi	vidual deductibles for spetitic services Medical	\$0	\$50	0
dividual	Brand Drugs Dental CVA-of-pocket maximum	\$0 \$0 \$2,250	\$50 \$0 \$2,2	
Commo edical Ev		Member Cost Dedu Share App	otible Member Cost	Deductibl Applies
ealth can rovider's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$3	\$15	
fice or inic viali	Specialist visit	\$5	\$20	
	Preventive care/ screening/ immunization Laboratory Tests	No cost share	No cost share \$15	
ists	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Generic drugs	\$5 \$50 \$3	\$20 \$100 \$5	
uga lo tr nass or nacion	Preferred brand drugs Non-preferred brand drugs	\$5 \$10	\$15 \$25	X X
ripatient Egery	Specialty drugs Facility fee (e.g., ASC) Physician/surgeon fees	10% 10% 10%	15% 15% 15%	X
ed .	Emergency room services (waived if admitted) Emergency medical transportation	\$25 \$25	\$75 \$75	X
mediate lention	Urgent care	\$6	\$30	
epilal st	Facility fee (e.g. hospital room) Physician/surgeon fee	10%	15%	х
	Mental/Behavioral health outpatient services	\$3	\$15	
mtel hea havioral elth, or	Mental/Behavioral health inpatient services	10%	15%	X
batance use neud	Substance use disorder outpatient services	\$3	\$15	
	Substance use disorder inpatient services	10%	15%	Х
ignancy	Prenatal care and preconception visits	No cost share	No cost share	
	Delivery and all inpatient services Professional Home health care	10% \$3	15% \$15	X
ip Lovering		\$3 \$3 10%	\$15 \$15	v
ier spesi ulti nees	Durable medical equipment	10%	15% 15%	X
lid eye	Hospice service Eye exam	No cost share	No cost share No cost share	
•	pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No cost share	No cost share	
lid Denta ignostic i ventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered	Not Covered	
iid Denta sic vices	Amalgam Fill - 1 Surface	Not Covered	Not Covered	
id Dente	Extraction- Single Tooth Exposed Root or	Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered	
vices	Erupted Extraction- Complete Bony Porcelain with Metal Crown	Not Covered Not Covered	Not Covered Not Covered Not Covered	Manager and Company
ild hodentic	Medically necessary orthodontics	Not Covered	Not Covered	

2015 Standard Benefit Plan Designs 9.5 EHB

Member Cost S	Share amounts describe the Enrollee's out of	Silver Copa 200%-250%	
	e - AV Calculator	73.50%	
ndividual Ov	orall deductible yal deductibles for specific services	N/A	
imer inasviol	Medical	\$1,600)
	Brand Orugs Dental	\$250 \$0	
ndividual Ou	r-ci-posket maximum	\$5,200)
Common		Member Cost	Deductible
Medical Even	t Service Type	Share	Applies
lealth care	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$40	
Mice or	Specialist visit	\$50	
linic visit	Preventive care/ screening/ immunization	No cost share	
	Laboratory Tests	\$40	
lests .	X-rays and Diagnostic Imaging	\$50 \$250	
	Imaging (CT/PET scans, MRIs) Generic drugs	\$15	
Drugs to trea liness or	Preferred brand drugs	\$35	X
condition	Non-preferred brand drugs Specialty drugs	\$60 20%	X
Outpatient	Facility fee (e.g., ASC)	20%	
surgery	Physician/surgeon fees	20%	X
Need mmediate	Emergency room services (waived if admitted) Emergency medical transportation	\$250 \$250	X
attention	Urgent care	\$80	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20%	X
	Mental/Behavioral health outpatient services	\$40	
Mental healti behavioral health, or	Mental/Behavioral health inpatient services	20%	X
substance aliuse needs	Substance use disorder outpatient services	\$40	
	Substance use disorder inpatient services	20%	X
	Prenatal care and preconception visits	No cost share	
Pregnancy	Delivery and all inpatient Hospital services Professional	20%	x
	Home health care	\$40	
	Outpatient Rehabilitation services	\$40 \$40	
Help recovering o	Outpatient Habilitation services	\$40	
other specia	Skilled Hursing Care	20%	X
health needs	CANADA MARIA CANADA CAN	20%	
	Hospice service	No cost share	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share No cost share	
Child Dental	Oral Exam Preventive - Cleaning	and a second a second and a second a second and a second a second and a second and a second and	F
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface	Not Covered	
Services	Root Canal- Molar	Not Covered	
Child Dental	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or	Not Covered	
Major Services	Erupted	Not Covered	
	Extraction- Complete Bony Porcelain with Metal Crown	Not Covered Not Covered	
Child	Medically necessary orthodontics	Not Covered	

Summary	of Renefits	and Coverage

ocket cos	ost Share amounts describe the Enrollee's out of ts. /alues AV Galculator	Bronz 60.6	e Plan 50%	Bron HSA P 59.40	lan
dividual	Overall deductible	Employee Commission Co	ed Med/Rx Ded	\$4,500 integra	er more managed and a company of the com-
	vidual deductibles for specific services Medical Brand Drugs Dental Out-of-pocket maximum	ctel N/A d Drugs N/A stl \$0		N/A N/A N/A \$6,250	
Commo ledical E		Member Cost Share	Deductible Applies	Member Cost Share	Deductio Applies
ealth car roylder's frice or	Primary care visit or non-specialist grantitioner	\$60	After 1st three non- preventive visits	40%	х
linio visit	Specialist visit Preventive care/ screening/ immunization	\$70 No cost share	X	40% No cost share	X
1516	Laboratory Tests X-rays and Diagnostic Imaging	30% 30%	X X	40% 40%	X X
nigs to t	Imaging (CT/PET scans, MRIs) Generic drugs Preferred brand drugs	30% \$15	X	40% 40%	X X
ness or Indition	Non-preferred brand drugs Specialty drugs	\$50 \$75 30%	X X X	40% 40% 40%	X X X
utgery utgery	Facility fee (e.g., ASC) Physician/surgeon fees	30% 30%	X X	40% 40%	X X
boti	Emergency room services (waived if admitted) Emergency medical transportation	\$300 \$300	X	40% 40%	X
nmediate tention	Urgent care	\$120	After 1st three non- preventive visits	40%	x
aspitat si	Facility fee (e.g. hospital room) Physician/surgeon fee	30% 30%	X	40% 40%	X X
antal has	Mental/Behavioral health outpatient services	\$60	After 1st three non- preventive visits	40%	×
havioral alth, or	Mental/Behavioral health inpatient services	30%	x	40%	х
batance use nee	Substance use disorder outpatient services	\$60	After 1st three non- preventive visits	40%	x
	Substance use disorder inpatient services	30%	×	40%	X
egnancy	Prenatal care and preconception visits Delivery and all inpatient Hospital	No cost share	X	No cost share 40%	X
	services Professional Home health care	30% 30%	X	40% 40%	X
ilp covering	Outpatient Rehabilitation services Outpatient Habilitation services	\$60 \$60	X	40% 40%	X
horagas alkninas	Skilled nursing care	30% 30%	X	40% 40%	X X
	Hospice service	No cost share	X	No cost share	X
illd eye re	Eye exam 1 pair of glasses per year (or contact tenses in lieu of glasses)	No cost share No cost share		No cost share No cost share	
tiid Dent Agnostic d avantive	Preventive - X-ray Sealants per Tooth	Not Covered		Not Covered	
No Dent Isic Irvices	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
ild Dent ijot rvices	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	Not Covered		Not Covered	
illd	Medically necessary orthodontics	Not Covered		Not Covered	

2015 Standard Benefit Plan Designs 9.5 EHB

Summary	ωf	Renefite	and	Coverage
Summary	u	Denenis	anu	COVERAGE

ocket costs. ictuarial Valu	e - AV Calculator		Catastroph	
ndividual Ovi	rall deductible		\$6,600 integrated	Med/Rx De
ither individi	a) deductibles for specific Medical	Services	N/A	
	Brand Drugs		N/A	
ndividual Ox	Dental Gof-pocket maximum		N/A \$6,60	
Common		1.00	Member Cost	Deductible
ledical Even	Service T	уре	Share	Applies
lealth care rovider's	Primary care visit or non-sp visit to treat an injury or illne		0%	After 1st three non- preventive visits
filca or linto visit	Specialist visit		0%	Х
	Preventive care/ screening/	immunization	No cost share	
	Laboratory Tests		0%	X
ests	X-rays and Diagnostic Imag		0% 0%	X
	Imaging (CT/PET scans, Mi Generic drugs	715)	0%	^
rugs to treat	Preferred brand drugs		0%	X
Iness or andition	Non-preferred brand drugs		0%	X
lupations	Specialty drugs Facility fee (e.g., ASC)		0%	<u>X</u>
urgery	Physician/surgeon fees		0%	X
	Emergency room services (0%	X
leed	Emergency medical transpo	rtation	0%	X
rmediate Hention	Urgent care		0%	After 1st three non- preventive visits
lospital stay	Facility fee (e.g. hospital roo Physician/surgeon fee	om)	0% 0%	X
	Mental/Behavioral health ou	itpatient services	0%	After 1st three non- preventive visits
tental health ehavioral	Mental/Behavioral health in	patient services	0%	x
ealth, or ubstance buse needs	Substance use disorder out	patient services	0%	After 1st three non- preventive visits
	Substance use disorder inp	atient services	0%	X
	Prenatal care and preconce	ption visits	No cost share	
regnancy	Delivery and all inpatient	Hospital	0%	X
	services	Professional	0%	X
	Home health care Outpatient Rehabilitation se	rvices	0%	X
lelp	Outpatient Habilitation servi	enganoscomergos ero elemente de entra de la companya del companya de la companya de la companya del companya de la companya del la companya del la companya de la companya	0%	×
ecovering or	Skilled nursing care		0%	X
ther special realth needs	Durable medical equipment		0%	X
	Hospice service		No cost share	X
hild eye	Eye exam 1 pair of glasses per year (d	or contact lenses in lieu	No cost share	
are	of glasses)		No cost share	x
had Dental	Oral Exam Preventive - Cleaning			
Pagnostic	Preventive - X-ray		No cost share	
nd	Sealants per Tooth		INO COST SHALE	Energy con-constitution
reventivo	Topical Fluoride Application Space Maintainers - Fixed			ļ
hild Dental Isalc	Amalgam Fill - 1 Surface		Not Covered	
ervices	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Ex	posed Root or	Not Covered	
Aajor Services	Erupted Extraction- Complete Bony Porcelain with Metal Crown		Not covered	
hila	Medically necessary orthod	ontics	Not Covered	
		The state of the second st		CONTRACTOR

2015 Standard Benefit Plan Designs 9.5 EHB

Notes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for the deductibles in High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the in-network family deductible and out of pocket maximum. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the carrier pays all costs for covered services for all family members.
- 2) For HDHPs linked to HSAs, in a family plan, each individual in the family must meet a deductible of \$2,600 until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in a family plan, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
- Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
- 5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 6) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month.
- 7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
- 8) For drugs to treat an illness or condition the copay or coinsurance applies to the prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.



Basic Services

eriodontics.

Orthodontia

urgery

lajor Services - Crowns

nd Casts, Endodontics,

rosthodontics, Oral

2015 Dental Standard Benefit Plan Designs

Summary of Benefit	Standalone Dental Plan		Standalone Dental Plan		
Member Cost Share amor costs.	Pediatric Dental EHB Copay Plan		Pediatric Dental EHB Coinsurance Plan		
	Up to Age 19		Up to Age 19		
Actuarial Value	83.0%		86.8%		
Individual Deductible (w	\$0		\$65 In Network/ \$65 Out of Network		
Family Deductible (Two waived for Diagnostic &	\$0 \$350 \$700		\$130 In Network/ \$130 Out of Network \$350 \$700		
ndividual Out of Pocket					
amily Out of Pocket Ma					
Office Copay	\$0		\$0		
Waiting Period Waitered Condition provision, a 357.50 (s)(3)(3)(4), and historar	None Particles and the second second		None		
Annual Benefit Limit the maximum amount the denta	None		None		
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Oral Exam	\$0		0%	
	Preventive - Cleaning	\$0		0%	
Diagnostic & Preventive	Preventive - X-ray	\$0		0%	
anightane a riesennic	Sealants per Tooth	\$0		0%	

\$0

\$0

\$25

\$300

\$150

\$65

\$160

\$300

\$350

0%

0%

20%

50%

50%

х

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

or Erupted

Topical Fluoride Application

Space Maintainers - Fixed

Amalgam Fill - One Surface

Extraction - Complete Bony

Crown - Porcelain with Metal

Medically Necessary Orthodontia

Extraction- Single Tooth Exposed Root

Root Canal - Molar

Gingivectomy per Quad

- In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.



2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Date: April 17, 2014											
Summary of Benefits and Coverage		Family Dental Plan									
Member Cost Share amounts describe the Enrollee's out of pocke costs.		Pediatric Dental EHB Copay Plan Up to Age 19 83.0%		Adult Dental Copay Plan Age 19 and Older Not Calculated							
						ndividual Deductible (waived for Diagnostic & Preventive)		\$0		\$0	
						family Deductible (Two or more children) waived for Diagnostic & Preventive)		\$0		\$0	
ndividual Out of Pocke		\$350		Not Applicable							
Family Out of Pocket M	eximum (Two or More Children)	\$700 \$0 None		Not Applicable \$0 None							
Office Copay											
Walting Period (Velvered Condition prevision) 1357,50 (a)(3)(J)(4) and insura	as defined in Health & Safety Code noë Code 10198 8 (10)(d)										
Annual Benefit Limit (the meximum emount the dens	If plan will pay in the benefit year).										
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies						
Diagnostic & Preventive Basic Services Major Services - Crowas and Casts, Endodontics, Periodontics, Prosthodontics, Orat Surgery	Oral Exam	\$0		\$0							
	Preventive - Cleaning	\$0		\$0							
	Preventive - X-ray	\$0		\$0							
	Sealants per Tooth	\$0		Not Covered							
	Topical Fluoride Application	\$0		Not Covered							
	Space Maintainers - Fixed	\$0		Not Covered							
	Amalgam Fill - One Surface	\$25		\$25							
	Root Canal - Molar	\$300		\$300							
	Gingivectomy per Quad Extraction- Single Tooth Exposed Root	\$150 \$65		\$150 \$65							
	or Erupted Extraction - Complete Bony	\$160		\$160							
	Crown - Porcelain with Metal	\$300		\$300							
Orthodontia	Medically Necessary Orthodontia	\$350		Not Covered							

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

- In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.



2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014 Family Dental Plan **Summary of Benefits and Coverage** Pediatric Dental EHB **Adult Dental** Member Cost Share amounts describe the Enrollee's out of pocket Coinsurance Plan Coinsurance Plan costs. Up to Age 19 Age 19 and Older Not Calculated 86.8% \$65 In Network/ \$50 In Network/ ndividual Deductible (waived for Diagnostic & Preventive). \$50 Out of Network \$65 Out of Network \$130 In Network/ amily Deductible (Two or more children) Not Applicable valved for Diagnostic & Preventive) \$130 Out of Network ual Out of Pocket Maximum \$350 Not Applicable Not Applicable \$700 nily Out of Pocket Maximum (Two or More Children). \$0 \$0 6 months for Major aiting Period Services, Waived with Proof None od Condition provision, as defined in Health & Safety Code (a)(3)(4)(a) and insurance Code (0)(9)(6)(10)(d) of Prior Coverage \$1,500 None Member Cost Deductible Member Cost | Deductible Service Type **Procedure Category Applies** Share Applies Share 0% 0% Oral Exam 0% Preventive - Cleaning 0% 0% Preventive - X-ray 0% liagnostic & Preventive 0% Not Covered Sealants per Tooth Not Covered Topical Fluoride Application 0% Not Covered Space Maintainers - Fixed 0% Amalgam Fill - One Surface 20% 20% X Root Canal - Molar ajor Services - Crowns nd Casts, Endodöntics, Gingivectomy per Quad Extraction- Single Tooth Exposed Root 50% 50% or Erupted esthodontics, Oral Extraction - Complete Bony urgery

50%

Not Covered

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.

Crown - Porcelain with Metal Medically Necessary Orthodontia

- 2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.